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ABSTRACT

Two programs developed by the State of North Carolina are described which are designed to provide special services to the mentally retarded incarcerated adult male. Based on results of an assessment of adaptive skills believed relevant to coping in the prison population, coupled with an intellectual quotient (IQ) below 70, offenders may be placed in an inpatient program in a specialized, segregated facility. Individuals have the right to contest their placement on this specialized unit. The need for bathrooms in single cells used in time-out procedures, as well as the need for increased staffing on the segregated unit, are noted. Mentally retarded inmates retained in the general prison population may participate in such specialized programs as compensatory or adult basic education, hortitherapy, activity therapy, arts and crafts, anger management, and individual psychotherapy. An Orientation and Adjustment group is designed to provide the inmate with general knowledge about the institution, the function of personnel and facilities, possible job training, and basic skills such as hygiene. A support group provides reinforcement and peer support for the behaviors learned in Orientation and Adjustment. (JW)

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The Treatment of the Mentally Retarded Offender In The State of North Carolina

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THE TREATMENT OF THE MENTALLY RETARDED OFFENDER IN THE STATE OF NORTH CAROLINA

Mental retardation, based on intellectual testing alone indicates that some two to three percent of the adult male population, incarcerated in the State of North Carolina are diagnosable as mentally retarded. The State of North Carolina has developed two programs which work in conjunction to provide the special services needed by this population. The two programs provide for more intensive contact than is ordinarily provided to general population inmates. One of these programs is designed to separately house the mentally retarded inmate inorder to provide even more intensive interventions. These inmates who are separately housed tend to be more impulsive, more aggressive, and more difficult to manage than the general population inmate and more difficult to manage than the average mentally retarded inmate in the prison population.

The State of North Carolina presently houses 17,000 inmates. Of these, 2.3 percent are identified as mentally retarded. This is approximately 400 inmates presently incarcerated in North Carolina diagnosed as mentally retarded based on intellectual evaluation alone. Of these 400 inmates, the majority fall in the mildly mentally retarded classification based on intellectual functioning alone. Probably one to two percent of the identified mentally retarded fall in the moderately mentally retarded level of intellectual assessment. I am not presently aware of any profoundly or severely mentally retarded inmate in the prison population.

In 1982, the North Carolina Department of Corrections fearing a law suit decided to provide treatment and care for the mentally retarded needing such treatment and care. The department settled upon two broad programs for the treatment of the mentally retarded offender in the State of North Carolina. The first of these programs is similar to a Mental Health Center or Outreach-type of program.

The second program, is more similar to an inpatient hospitalization model. When inmates are initially processed into the prison system, they are administered a number of tests including the MMPI and the BETA II. Following screening by the BETA II Intelligence Test, those inmates whose scores fall at or below a defined cutting level, are then re-evaluated with an individual assessment of intelligence. At this point, approximately 2.3 percent of the inmates are identified as mentally retarded and a decision is made as to whether the inmate will be placed in the general population and tracked or placed in the specialized, segregated inpatient type facility.

Those patients who are referred for outpatient population will be tracked throughout their stay with the Department of Correction. In addition to being followed throughout their course and identified as being mentally retarded, the inmates will be seen on at least a monthly basis by a specially trained Mental Retardation Case Manager. The Mental Retardation Case Manager is an individual typically with at least a High School Education who has been to a six hour training course to enlighten the individual on the nature of retardation and it's consequences for the individual. Specific emphasis is given to the many myths surrounding mental retardation including such myths as hypersexuality, asexuality, increased aggression or violence, an inability to learn, and other similar myths. In addition to debunking some of the myths surrounding mental retardation, some effort and discussion is given to elucidating specific problems

that the mentally retarded have and specific problems that the mentally retarded will have within the prison population. These Case Workers are typically drawn from a pool of Officers or Program Assistants working at the facility. The Case Worker for the mentally retarded identifies mentally retarded inmates at their intake to the facility by means of a computerized tracking sheet which is initiated during the processing of the individual. In addition to the typical duties and responsibilities that the individual would have in seeing after inmates in the institution, the person would be expected to spend additional time, at least once per month, talking to the inmate, interviewing the inmate, and attempting to address any problems that the inmate was having adjusting to the population or dealing with problems in the population. Typically, these sessions are rather brief but generally address custodial issues such as an emphasis upon the individuals remaining infraction free and avoiding infractionary behaviors.

A small percentage, less than ten percent, of the mentally retarded inmates are identified as having adaptive skills deficits which are problematic within the prison system. This identification may occur at processing but more often occurs when the individual has been placed in the general population and is unable to deal with or cope with the problems presented in general population. These individuals are seen by a member of the Psychology staff and an adaptive skills deficit form is completed. While the form is patterned after the AAMD it is an extremely brief ten item checklist with few empirical anchor points. Generally, the form assesses items believed to be relevant to coping in the prison population such as understanding and following orders, the ability to manage one's money, the ability to take care of one's personal hygiene and such similar items. Failure in any one of these areas, of twelve areas assessed, coupled with an individualized intellectual assessment below 70 IQ points is indicative of justification for placement on the Specialized Inpatient Unit.

Prior to housing on the specialized unit, the mentally retarded and the mentally ill have an opportunity to contest their placement on a specialized unit. This policy was instituted in 1986 after an adverse court ruling. The function of the hearing is to provide a quasilegal hearing patterned after the States comitment procedures. Interestingly, while both the mentally ill and the mentally retarded have this right the mentally retarded exercise it at a much higher rate than do the mentally ill.

The inpatient unit is presently housed in a close custody institution in Maury, N.C. The facility is a modern facility with a single cell environment. Initially, the mentally retarded were segregated in to one thirty (30) man wing of a ninety (90) man housing area in the institution. The other sixty (60) beds were held by mentally ill patients. At present, because of staffing considerations, increased flexibility in housing the mentally retarded and the mentally ill as well an attempt to provide housing based on merit and advancement rather than diagnosis. The mentally ill and mentally retarded are now housed together in the ninety (90) man unit.

In the specialized Mental Health/Mental Retardation Unit, a number of programs specifically designed for the mentally retarded are provided in addition to the programs which are generically provided for the mentally ill/mental retarded. Among those programs specifically designed for the mentally retarded are educational programs specifically Compensatory Education and in some cases, Adult Basic Education. Further, psycho-educational groups exist which provide what we refer to as Orientation and Adjustment and a Support Group. The Orientation and Adjustment Group is designed to provide the inmate with the general knowledge and lay-out of the institution, the function of Custody Officers, the function of various facilities within the institution, the possibility of jobs and job training and such similar activities. Part of this orientation and adjustment is such basic skills as learning to read the time, learning proper hygiene techniques and similar activities. The Support Group which is primarily a program for the mentally retarded is designed to provide reinforcement and peer support for the behaviors learned in Orientation and Adjustment.

Among the general groups and activities that are available for the mentally retarded are Hortitherapy, Activity Therapy including sports and exercise, Arts and Crafts, Anger Management, Individual Psychotherapy, Individualized Behavior Plans and a general quasi-behavioral therapeutic milieu.

While it should be noted that the mentally retarded inmates that are admitted to the Inpatient Unit are probably the worst of the mentally retarded inmates, they do present far more problems than the average mentally retarded inmate retained in the general population and they have a higher incidence of problematic behavior than exists in the general population. Specifically, these inmates fall into roughly two categories. The first is a category marked by impulsive, typically aggressive acting-out which is frequently described as bullying and a more passive marginal adjustment which allows these inmates to be particularly easy prey by inmates in general and more aggressive inmates in particular. Because of these two types of mentally retarded inmates, the mentally retarded inmates were crudely separated into the more aggressive and the more passive when integrated into the mentally ill population.

General observations about the more aggressive mentally retarded individual indicate that these persons tend to be very impulsive, very angry and verbally and occasionally physically assaultive. Their verbal and physical assaults may be no more prevalent than in the general population, however, it appears that these individuals are less able to cover up their behaviors and therefore are more likely to receive infractions. Similar observations might be made about the more passive individuals. That is, they tend to be sexually promiscuous which results in infractionary behavior or in the absence of sexual infractions, their inability to or lack of skills in managing their money results in indebtedness or problems in which other inmates fight over taking advantage of or taking charge of their money. Taken together, these problems in the mentally retarded are the reasons which results in them being placed in the specialized inpatient unit at a higher frequency than in the general populations.

The housing in Eastern Correctional Center at Maury for the mentally retarded suffers from three (3) distinct problems. First, the mentally retarded, particularly the more assaultive/aggressive mentally retarded, are best dealt with with time-out procedures or segregating them in their cell. Unfortunately, we do not have single cells that have bathrooms in them. In designing prison facilities for inmates that are mentally retarded, I would strongly advise that these inmates receive bathrooms within their cells in the event that it becomes necessary to segregate them to their cell. A second problem, which is related, is that frequent short-term segregation is staff intensive. In general, while all facilities are no doubt under staffed, this is particularly the case in a prison in which the system is set up primarily to protect the greater society from the inmates. Accordingly, staffing and budgetary considerations are primarily aimed at providing a minimal number of providers and therefore, despite acute concern to this area by mental health providers and the Superintendent of the institution there are not adequate staff on the Unit to provide frequent segregations of the inmate even if the single cells had bathrooms. Therefore, my second recommendation would be that particularly with the mentally retarded population, consideration be given to a large body of staff on the Mental Retardation Unit. While professional staff are certainly necessary and helpful in the running of the Unit and in providing services to the mentally retarded, the inmate's problematic behavior is so much greater than with the mentally ill population, I would have to argue that it is more important to have lower level staff to interact with the mentally retarded at a higher rate than high quality, low frequency interactions afforded by professional staff.

In closing, I would like to bring up two distinct issues which probably have not been adequately addressed and which create problems for those of us treating the mentally retarded in the prison system. The first is the question of which skills we the treating staff are supposed to be remediating. That is to say, should we be providing the mentally retarded inmate with the skills to manage themselves in the general prison population or should our goal be to provide them with the skills to manage themselves in society at large. These are not necessarily the same skills. For example, in the passive more inadequate mentally retarded inmate, it might be helpful to teach the inmate to be more firm, more assertive, and more "convict like". However, these skills may not be as useful in real world general population as are their skill deficits of passivity and helplessness. On the other hand, if the focus of treatment for the inmate is to provide them with the skills, the vocational training, and other necessary learning opportunities that would prepare the individual for functioning in the real world, there are a number of problems presented not the least of which is the staffing intensity and the financial burden that it would present. There are of course those inmates who have Life or multiple Life sentences and who in all probability will never leave the institution.

A second problem is more of a long-term problem related to the problem of training the inmate. Specifically, when it comes time for these inmates to be placed on probation or parole, the mentally retarded inmates are less likely to be favorably reviewed by the Parole Board. There are a number of reason for this. Among the reasons are the difficulty in finding adequate placement for the individual once he leaves prison since he is viewed as multiply handicapped having both a prison sentence and mental retardation and in many cases, a

physical or other psychiatric/psychological diagnosis. The Parole Board must also consider the fact that these inmates tend to be admitted with more aggressive or violent crimes than the general population inmate and therefore, have a high probability of similar behaviors when they leave. Finally, since presently, most of the skills training has been to provide the mentally retarded inpatient with minimal skills necessary to exist within the prison system, and those mentally retarded who were not accepted into the inpatient system received no training, it is unlikely that these inmates have the skills to manage themselves in the general population.

In general, the mentally retarded inmate population is overwhelmingly diagnosed as mildly mentally retarded and is somewhat more violent and somewhat more impulsive than the average general population inmate. These inmates are classified at processing and are placed into either an inpatient specialized housing or are followed throughout their prison sentence as outpatients. In general, the skills that these people came to prison with are very similar to the ones that they will leave prison with. This is a small on the order to two (2) percent portion of the prison population but a significant one both for the resources that it demands and for the problems that these inmates present.

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